

Anesthesia Services

Anesthesia

Wisconsin Medicaid-covered services provided by a certified registered nurse anesthetist (CRNA) or an anesthesiologist assistant (AA) include those anesthesia services prescribed by a physician within the scope of practice permitted CRNAs and AAs by their professional standards of practice.

Supervision Requirements

Nurse anesthetist and anesthesiologist assistant services must be provided in the presence of a supervising anesthesiologist or a performing physician, according to HFS 107.065, Wis. Admin. Code.

For billing purposes, CRNA and AA services are considered either *medically directed* or *medically supervised*. Anesthesiologist assistants must work under the medical direction of an anesthesiologist who is physically present during the provision of services. Nurse anesthetists may be either medically directed by an anesthesiologist or medically supervised by the attending physician.

Medically Directed Anesthesia Services

Medically directed anesthesia services are those services performed by a CRNA or an AA and directed by an anesthesiologist. When a CRNA or AA is medically directed, the anesthesiologist must do *all* of the following:

1. Perform pre-anesthesia examination and evaluation.
2. Prescribe the anesthesia plan.
3. Personally participate in the most demanding procedures of the anesthesia plan, including induction and emergence, if applicable.
4. Monitor at frequent intervals the course of anesthesia administered.

5. Remain physically present and available for immediate diagnosis and treatment of emergencies.
6. Indicate post-anesthesia care.

Medically Supervised Anesthesia Services


Medically supervised anesthesia services are those services performed by a CRNA and supervised by the attending physician. When a CRNA is medically supervised, the attending physician:

1. Reviews and verifies the pre-anesthesia evaluation performed by the CRNA.
2. Reviews the anesthesia plan, including medication.
3. Reviews and comments during pre-anesthesia care.
4. Reviews and comments during post-anesthesia care.

Medically Directed vs. Medically Supervised Anesthesia Services

For medically directed anesthesia services, an anesthesiologist is present during critical points in the procedure and is immediately available for diagnosis and treatment of emergencies. However, when a CRNA is medically supervised by the attending physician, an anesthesiologist does not have to be present during critical points in the procedure or immediately available for diagnosis and treatment of an emergency.

Anesthesiologist assistants must perform services under the medical direction of an anesthesiologist. Therefore, they *cannot* perform medically supervised anesthesia services.

 For billing purposes, CRNA and AA services are considered either *medically directed* or *medically supervised*.

Billing Medically Directed or Medically Supervised Anesthesia Services

Indicate on the HCFA 1500 claim form whether a procedure was medically directed or medically supervised by using an appropriate modifier following the procedure code. Refer to the modifier information in this chapter for more detail.

Procedure Codes

Wisconsin Medicaid coverage of anesthesia services is based on the surgical, therapeutic, or diagnostic procedure performed by the surgeon and identified by the *Current Procedural Terminology* (CPT), HCFA Common Procedure Coding System (HCPCS), or the appropriate dental procedure code which best describes the procedure performed.

Note: Wisconsin Medicaid does not recognize the CPT anesthesia codes (00100-01999), except on Medicare crossover claims.

General anesthesia is a covered service for dental procedures when necessary to control pain during surgeries or when it is medically necessary to manage a patient who presents physical or mental problems while providing dental care.

Refer to Appendix 1 of this handbook for Wisconsin Medicaid-allowable procedure codes, type of service (TOS) codes, and place of service (POS) codes for CRNA and AA services.

Modifiers

All claims for general anesthesia must include a procedure code followed by a modifier. The modifier indicates whether the service was medically directed (CRNAs or AAs) or medically supervised (CRNAs only). Nurse anesthetist and anesthesiologist assistant claims without an allowable modifier are denied. Refer to Appendix 1 of this handbook for a list of Wisconsin Medicaid-allowable modifiers.

Medical Direction Example: In a surgical session lasting an hour and a half, a CRNA is the only CRNA or AA medically directed for the first 30 minutes. But, the medical direction changes during the surgical session, and additional CRNAs or AAs are directed by the anesthesiologist for the final hour.

In this case, the CRNA would bill using the modifier WP, as the medical direction applying to the greatest period of time is for medical direction of two, three, or four CRNAs or AAs.

When the medical direction changes during a surgical session, indicate the modifier that applies to the *greatest* period of time. The example in the shaded box illustrates which modifier to indicate in this type of scenario.

For the quantity required in Element 24G of the HCFA 1500 claim form, indicate the number of 15-minute time units for the entire surgical session. If the period of time in each situation is *equal*, you may choose which modifier to use.

Note: Wisconsin Medicaid does not recognize patient status modifiers P1-P6, as described in the anesthesia section of CPT, or the HCPCS modifiers QY, QK, AD, and AE for the supervision of anesthesia.

Time Units

Anesthesia time must be billed to Wisconsin Medicaid in 15-minute time units in Element 24G (Days or Units) of the HCFA 1500 claim form. *Do not indicate the time in minutes or hours.* Anesthesia time begins when the CRNA or AA physically starts to prepare the recipient for the induction of anesthesia in the operating room and ends when the CRNA or AA is no longer in constant attendance (when the recipient may be safely placed under postoperative supervision).

Do *not* bill relative value units (RVUs) for the procedure performed because Wisconsin Medicaid automatically includes Medicaid RVUs when reimbursement is calculated. Do not add RVUs and time units.

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Wisconsin Medicaid does *not* reimburse separately for anesthesia time when an epidural anesthesia procedure is performed, except as part of labor and delivery.

Wisconsin Medicaid reimburses anesthesia only for the CPT procedure code applicable to the *major* surgical, therapeutic, or diagnostic procedure performed when multiple procedures are performed in a single surgical session. Assign to that procedure code the number of 15-minute time units involved in the *total* surgical session.

Use the following guidelines to determine the number of units to bill:

Rounding Guidelines

Time (in minutes)	Unit(s) Billed
1-15	1.0
16-30	2.0
31-45	3.0
46-60	4.0
etc.	

Additional Nurse Anesthetist or Anesthesiologist Assistant

An additional CRNA or AA may be required in certain surgical situations. Reimbursement for the additional provider is established by the Medicaid physician consultant.

Standby Nurse Anesthetist or Anesthesiologist Assistant

Wisconsin Medicaid reimburses for a standby CRNA or AA when the attending physician requests a CRNA or AA be immediately available on the premises. The standby CRNA or AA monitors the recipient's vital signs and observes the recipient, even though the surgery is actually performed under local anesthesia. Wisconsin Medicaid reimburses the standby CRNA or AA as if general anesthesia had been administered. A standby CRNA or AA is covered only when medically necessary and documented in the recipient's medical record.

Standby anesthesia is not covered when anesthesia, including an epidural, has already been administered.

To bill for a standby CRNA or AA, include the following on the HCFA 1500 claim form:

- The procedure code best describing the procedure performed.
- TOS "7."
- The number of 15-minute time units the CRNA or AA was face-to-face with the recipient or immediately available on the premises during a procedure.

Emergency Intubation

Nurse anesthetists and anesthesiologist assistants may be reimbursed for emergency intubations performed in a hospital unit other than the operating room. The procedure should be billed as a one-time event using procedure code 31500 (intubation, endotracheal, emergency procedure) and surgical TOS "2." Indicate a quantity of "1.0" when billing for intubation. Do *not* indicate the number of 15-minute time units as the quantity.

Epidural Anesthesia

Wisconsin Medicaid does *not* reimburse separately for anesthesia time when an epidural anesthesia procedure is performed, except as part of labor and delivery. Refer to the example on the following page to determine time units for an epidural anesthesia performed as part of labor and delivery.

Obstetrical

A CRNA or AA's time spent in attendance with an obstetrical patient receiving epidural anesthesia as part of labor and delivery may be reimbursed. Time spent in attendance includes:

- Initiation of the epidural.
- Initial care.
- Intermittent face-to-face monitoring.
- Discontinuation of the epidural.

Providers should bill the appropriate labor and delivery procedure code, TOS "7," and appropriate 15-minute time units. Document in the recipient's medical record or anesthesia report the time actually spent in constant attendance with the recipient.

Example: Epidural Anesthesia for Labor
CPT Code 62318. Bill for procedure then add time units as follows (15 minutes = 1.0 unit)

Time (24-hour clock)	Description	Time units
2230 - 2245	Epidural catheter inserted; prepare and drape; check blood pressure and pulse	1.0
0200 - 0215	Check previously inserted epidural catheter, blood pressure, and pulse	1.0
0415 - 0430	Check previously inserted epidural catheter, blood pressure, and pulse	1.0
0510 - 0530	Baby girl delivered at 0530; check blood pressure and pulse	2.0
0540 - 0555	Epidural catheter removed intact; sterile dressing applied to puncture site	1.0
	Billable units	6.0

Wisconsin Medicaid does *not* reimburse for standby CRNA or AA services provided to patients who have received an epidural during labor delivery.

Postoperative and Intractable Pain Management

Wisconsin Medicaid reimburses CRNAs and AAs for epidural procedures when, for example, they are provided for management of postoperative or intractable pain. Indicate the appropriate CPT surgical code related to epidural anesthesia, TOS “2,” and a quantity of “1.0.” Do *not* indicate the number of 15-minute time units as the quantity.

Any subsequent daily visit with the recipient related to the epidural procedure should be billed with the appropriate CPT evaluation and management procedure code and TOS “1.” If more than one visit is required, submit an Adjustment Request Form (refer to Appendix 7 of this handbook) with appropriate documentation and state “Medical Consultant Review Requested.”

Invasive Monitoring

Procedure Codes

Wisconsin Medicaid reimburses the following invasive monitoring procedure codes separately when performed by a CRNA or AA and billed with TOS “7:”

Code	Description
36488	Placement of central venous catheter; percutaneous, age 2 years or under.
36489	Placement of central venous catheter; percutaneous, over age 2.
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion; percutaneous.
93503	Insertion and placement of flow directed catheter for monitoring purposes.

Units

Indicate “1.0” in Element 24G of the HCFA 1500 claim form when billing for invasive monitoring.

Vascular Procedures

Procedure Codes

A CRNA or AA may be separately reimbursed for vascular procedures when performed in situations *other than* in the surgical suite. In these situations, the following CPT vascular procedures should be billed with TOS “2”:

Code	Description
36000 to 36248	Intravenous and Intra-Arterial/ Intra-Aortic injections.
36488 to 36491	Placement of central venous catheter.
36600 to 36660	Arterial catheterization.

Units

When billing for vascular procedures, indicate the number of procedures performed in Element 24G of the HCFA 1500 claim form. Do *not* bill time units.

A CRNA or AA may be separately reimbursed for vascular procedures when performed in situations *other than* in the surgical suite.